BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MIRIAM A. ARCE, M.D.** Holder of License No. 15645 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-06-1026A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Miriam A. Arce, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that she has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

MIRIAM A. ARCE, M.D.

DATED: 8/20/07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 15645 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-1026A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a sixty year-old male patient ("DL").

4. On September 21, 2004, DL presented to Respondent with a chief complaint of breathing problems. Respondent examined DL and noted he did not have heart failure. Despite a lack of documentation of a complete evaluation, including DL's history of present illness and symptoms related to the presenting complaint, including basic symptom variance with exertion, recumbence of paroxysmal nocturnal onset or intensification; Respondent diagnosed DL with shortness of breath, obesity and thyromegaly and prescribed Advair, a bronchodilator inhaler asthma treatment medication. Respondent's clinical impression was that DL's obesity resulted in the acute dyspnea and fatigue symptoms. Respondent instructed DL to call if his symptoms worsened.

5. On October 1, 2004, DL died of coronary artery disease and apparent heart failure. The autopsy revealed the cause of death was hypertensive and atherosclerotic cardiovascular disease.

6. In response to the Board's investigation, Respondent submitted a one page medical record dated September 21, 2004. The medical record showed Respondent treated DL for dyspnea with a bronchodilator inhaler without confirming bronchospasm and without excluding multiple serious conditions, including palpitations. Respondent also deferred gastrointestinal ("GI") testing even though a rectal examination directly pertaining

to DL's fatigue symptoms could have identified a GI blood loss based anemia. Additionally, Respondent's intake evaluation was illegible and she used nonstandard abbreviations.

7. The standard of care requires a physician to recognize acute onset of dyspnea in a sixty year-old male as a chest pain equivalent when an alternate explanation is not identified.

8. Respondent deviated from the standard of care because she did not recognize acute onset of dyspnea as a chest pain equivalent in DL. Respondent treated DL for a bronchospasm and did not consider multiple serious conditions.

9. The standard of care requires a physician to obtain a stool Hemoccult test to identify possible GI blood loss based anemia.

10. Respondent deviated from the standard of care because she did not obtain a stool Hemoccult test from DL to identify possible GI blood loss based anemia. Respondent deferred DL's GI testing.

11. Respondent's failure to recognize acute onset of dyspnea as a chest pain equivalent and that fatigue was a possible source of anemia delayed proper diagnosis and treatment and as a result DL died.

12. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they were illegible, including using nonstandard abbreviations and she failed to document a complete evaluation.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to recognize acute onset dyspnea as a chest pain equivalent, for failure to perform an adequate evaluation and for failure to maintain adequate medical records.

2. This Order is the final disposition of case number MD-06-1026A.

DATED AND EFFECTIVE this 12th day of October, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of October, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 22 day of March, 2007 to:

Miriam A. Arce, M.D.
Address of Record

Investigational Review